OMB Number: 2900-0517
Estimated burden: 4 minutes
Expiration Date: 7/31/2004

Department of Veterans Affairs

VA Spina Bifida Healthcare Benefits
Claim for Miscellaneous Expenses

VA Health Administration Center **Spina Bifida** **PO Box 65025** **Denver CO** **1 • 800 • 733 • 8387**

Attention: After reviewing the following, complete form in its entirety (print or typewritten only) and return with required documentation. Limit entries to one character per block and do NOT exceed the designated space (i.e. do NOT extend last name into the First Name area).

Notes. This form is required for all claims for reimbursement of miscellaneous expenses related to the treatment of spina bifida and associated conditions. Regardless of the type of expense being claimed, completion of Sections I, II, and V are mandatory. Completion of Section III is required only for claims involving prescriptions, medical supplies and over-the-counter medicines, while completion of Section IV is required only for claims involving travel. If more space is needed, continue in the same format on a separate sheet. Reimbursement for approved expenses (including attendant travel/miscellaneous expenses) will be made payable to the beneficiary.

Section I - Patient Information

Last | First | MI | Social Security Number

Street | Date of Birth (mm/dd/yyyy)

City | State | Zip Code | Telephone Number (include area code)

Section II - Sponsor Information

Last | First Name | MI | Social Security Number

Section III - Prescriptions, Medical Supplies And Over-The-Counter Medicines

- Record on all receipts the *diagnosis* for which the drug/medicine/supply item was prescribed/required and *attach* receipts to claim form.
- If receipts are not itemized (a complete description, quantity, and price for each item), complete the following.

Description	Quantity	Date of purchase (mm/dd/yyyy)	Actual Cost
			$.
			$.
			$.

Section IV - Travel

Use SB Fact Sheet 97-11-2 as a guide & complete the following. Attach required receipts for expenses claimed (receipts for privately owned vehicle mileage (POV) excluded).

Certification of Medical Service (required for *all* travel claims)

Date of Service (mm/dd/yyyy) | Provider Tax ID Number | Provider signature certifying service on service date ✗

Patient Travel Information

Mode of Travel ☐ Airline ☐ Taxi ☐ POV (round-trip) → → → ☐ Bus ☐ Train ☐ Other → → → →

Date(s) of Travel	Departure: City	State	Time (i.e, 0815)	Arrival: City	State	Time (i.e, 0815)

Attendant Information

Last Name | First Name | MI | Relationship to Patient

Patient/Attendant Miscellaneous Expenses

Lodging $. | Other (parking, tolls, etc.) $.

Section V - Certification

RELEASE OF MEDICAL INFORMATION: Signature in this section authorizes the patient's providers to release medical record documentation related to the services associated with this claim. This consent pertains to all medical records, including records related to treatment for psychological and psychiatric conditions, drug and alcohol abuse, acquired immune deficiency syndrome, human immunodeficiency virus infection, and sickle cell disease.

→ ***I certify that the above information and attachments are correct and represent actual services, dates, and fees charged. (Sign and date on right) If certification is signed by a person other than the patient, complete the following.*** | Signature | Date

Last Name | First Name | MI | Relationship to Patient

Street Address

City | State | Zip Code | Telephone Number (include area code)

(tear at perforation and retain this portion for your records)

Spina Bifida - Claim for Miscellaneous Expenses

Appendix

Privacy Act: All information collected is subject to the provisions of the Privacy Act under 5 USC 522a. **Authority:** This information is solicited under 38 USC 501 and 1805 and 38 CFR 17.900 et seq. **Disclosure:** Disclosure is voluntary, but failure to provide the information may result in delay and/or denial of future Spina Bifida healthcare benefit claims. Failure to furnish this information will have no adverse impact on any other VA benefits to which the patient may be entitled.

Paperwork Reduction Act: This information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. This form is required for all claims for reimbursement of miscellaneous expenses related to the treatment of spina bifida and associated conditions.

VA FORM
JUL 1999 (R)

10-7959e